STUDENT CONSENT FORM FOR OPTIONAL COVID-19 POOLED TESTING

TO BE COMPLETED BY PARENT / GUARDIAN

Parent/Guardian Information

You will not be notified of pooled test results, but you will be notified of individual follow up test results either via phone or email.

Parent/Guardian Print Name:	
Parent/Guardian Cell/Mobile #: *Note: results will be texted to this cell #*	
Parent/Guardian Email Address:	

Child/Student Information

Child/Student Print Name:			
Sex:			
Address:			
School Name:			
Grade Level:		**Classroom** (if applicable)**:**	
Date of Birth: *(MM/DD/YYYY)*		**Age:**	
Race:		**Ethnicity:**	
Has the student listed above been diagnosed with COVID-19 in the past 90 days?:	☐ **Yes**, my student has tested positive for COVID-19 in the past 90 days. *If yes, list date of last positive COVID-19 test:* _____ ☐ **No**, my student has **not** tested positive for COVID-19 in the past 90 days.		

CONSENT

By completing and submitting this form, I confirm that I am the appropriate parent, guardian, or legally authorized individual to provide consent and I attest to:

A. I authorize the collection and testing of a weekly pooled COVID-19 test on my child during school hours, in addition to any necessary individual diagnostic follow up tests on my student (including Abbott BinaxNOW rapid antigen tests and PCR/molecular tests). I understand that all sample types will be non-invasive, short nasal swabs.

B. I understand that pooled testing does not yield individual results for each member of a pool, and that the results of my student's individual results within a pooled test cannot be shared with me. However, I understand that my student's personal health information may be entered into the testing provider's technology platform to assist with tracking pooled testing and identifying individuals in need of follow up testing.

C. I understand that I will be notified about the results of any individual diagnostic "follow up" test for COVID-19 performed on my student.

D. I understand that there is the potential for a false positive or false negative COVID-19 test result for pooled or individual tests. Given the potential for a false negative, I understand that my student should continue to follow all COVID-19 safety guidance, including mask-wearing and social distancing, and follow school protocols for isolating and testing in the event the student develops symptoms of COVID-19.

E. I understand that staff administering pooled testing and follow up testing have received training on safe and proper test administration. I agree that neither the test admnistrator nor the Lowell School District, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the pooled testing program.

F. I understand that my student **must** stay home if feeling unwell. I acknowledge that a positive individual follow up test result is an indication that my child, must stay home from school, self-isolate, and continue wearing a mask or face covering as directed in an effort to avoid infecting others.

G. I understand the school system is not acting as my child's medical provider, this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree I will seek medical advice, care and treatment from my child's medical provider if I have questions or concerns, or if their condition worsens. I understand I am financially responsible for any care my student receives from their healthcare provider.

H. I understand that follow-up testing will create protected health information (PHI) and other personally identifiable information of the student. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing company to transmit such PHI to my child's school, the Department of Public Health, the Department of Elementary and Secondary Education, and the testing provider. I further understand that PHI may be disclosed to the Executive Office of Health and Human Services and any other party, as authorized under HIPAA.

I. I understand that authorizing these COVID-19 tests for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested.

J. I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact the school nurse.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19 for my child.

Signature of Parent/ Guardian:		**Date:**